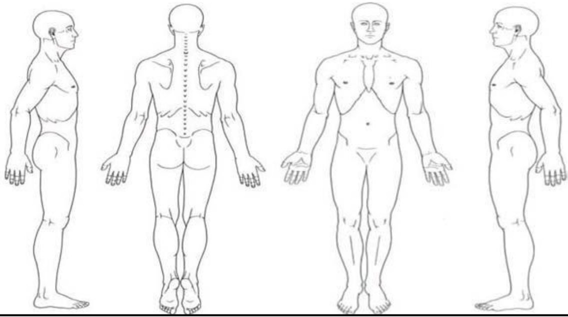
Please complete this form within a couple hours of each scheduled appointment. Thank you!

PATIENT CONDITION ASSESSMENT (PCA)

Name________________________________ **Patient Signature** ___________________________ **Date**__________

Please list you TOP 3 areas of complaint bothering you TODAY	CIRCLE ONE (0 = No Discomfort, 10 = Extreme discomfort
1. ____	0 1 2 3 4 5 6 7 8 9 10 OR Last Episode _____
2. ____	0 1 2 3 4 5 6 7 8 9 10 OR Last Episode ______
3. ____	0 1 2 3 4 5 6 7 8 9 10 OR Last Episode ______

Mark areas of CURRENT pain/discomfort below



Since Your last appointment, has your health complaints:

Please circle and identify the area

No Change ____

Improved Mildly ______________________________________

Improved Significantly _________________________________

Become Worse ____

Anything you need to communicate to us? Any new complaints?

____

____

____

____

BELOW IS FOR OFFICE USE ONLY

OFFICE VISIT	SERVICE	HERBAL / NUTRITIONAL	
EP EPR WHR	Acupuncture EAC Microcurrent / IF Laser Thermogram Cupping IR Heat	Herbs Supplements	

Recommendations:

Treatment:

Exam: